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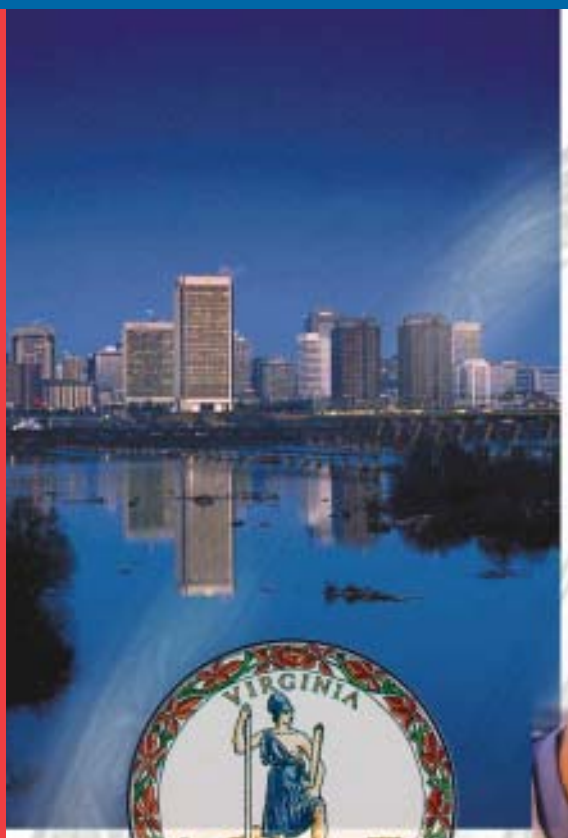

Commonwealth of Virginia Department of Medical Assistance Services

External Quality Review

UNICARE Health Plan of Virginia

SFY 2005

We don't provide healthcare... we make it better.

Section I - Operational Systems Review

Introduction

The operational systems review provides an assessment of the structure, process, and outcomes of the managed care organization's (MCO's) internal operating systems. The purpose is to identify, validate, quantify, and monitor problem areas in the overall quality assurance program. The review incorporated regulations set forth under the Final Rule of the Balanced Budget Act (BBA) of 1997 that became effective on August 13, 2002. The BBA is the comprehensive revision to federal statutes governing all aspects of Medicaid managed care programs as set forth in section 1932 of the Social Security Act and title 42 of the *Code of Federal Regulations* (CFR), part 438 et seq. In support of these regulations and MCO contractual requirements, as part of the calendar year (CY) 2004 review, Delmarva Foundation for Medical Care, Inc. (Delmarva) evaluated the following systems:

- Enrollee Rights and Protections—Subpart C Regulation
- Quality Assessment and Performance Improvement—Subpart D Regulation
  - Access Standards
  - Structure and Operation Standards
  - Measurement and Improvement Standards
- Grievance Systems—Subpart F Regulation

It is expected that each MCO will utilize the review findings and recommendations for operational systems improvement to become fully compliant with all standards and requirements.

Methodology

The operational systems standards used in the CY 2004 review were the same as those used in the 2003 review period (June through December 2003). These standards incorporate both the BBA and Medallion II contractual requirements. Specifically, in regards to the BBA, these standards include regulations under Subpart C, D, and F of the BBA.

The operational systems review for the period July 2003 through December 2003 was conducted on-site at each MCO. Each element received a compliance rating of "met," "partially met," or "not met." Each element that was not fully met in the 2003 review was assessed as part of the CY 2004 review.

The CY 2004 review of operational systems consisted of a desk review of all documents provided by the MCO to assess compliance with all elements that were partially met or not met in the 2003 review. This approach required Delmarva staff to conduct an evaluation of changes to policies, procedures, staff, and processes made by the MCO since the last review. The Delmarva team assessed all documentation provided by the MCO to assess whether or not the MCO had the administrative and operational systems in place and had implemented key operational policies and procedures to meet statutory requirements. During the process, the reviewers requested and the MCOs were asked to provide additional documentation or clarification where questions or concerns were identified.

As in the 2003 review, Delmarva review staff conducted the review, each element within a standard was rated as "met," "partially met," or "not met". Elements were then rolled up to create a determination of "met", "partially met," or "not met" for each of the standards related to enrollee rights and protections, quality assessment and performance improvement, and grievance system. Table 1 describes this scoring methodology.

Table 1. Rating Scale for Operational Systems Review

Rating	Rating Methodology
Met	All elements within the standard were met
Partially Met	At least half the required elements within the standard were met or partially met
Not Met	Less than half the required elements within the standard were met or partially met

The final element rating was determined as follows. All elements that were met in the 2003 review remained met for the CY 2004 review. All elements that were not fully met (partially met or unmet) were reviewed again and the CY 2004 review determination was applied. Therefore, the operational systems review scores for the CY 2004 should increase from the 2003 year if the MCO made efforts to address the elements that were not fully met in the 2003 review.

Results

The overall performance rating for each of the three major standards is found in Table 2.

Table 2. Operational Systems Review Results by Standard – Calendar Year 2004 Results

Performance Standard	Overall Performance Rating
Subpart C- Enrollee Rights and Protections	Partially Met
Subpart D- Quality Assessment and Performance Improvement	Met
Subpart F- Grievance Systems	Met

A total of 47 standards are evaluated as part of the operational systems review. Of the seven (7) Enrollee Rights standards, six (6) were met and only one (1) was partially met. All of the 29 Quality Assessment and Performance Improvement standards were met. All of the 11 Grievance Systems standards were fully met. None of the standards received a review determination of not met.

Results for each of the 47 operational systems review elements contain within each of the three standards are presented in Table 3. The number of "Met" review determinations is a cumulative sum; it includes the number of elements met in the 2003 review plus those met in the CY 2004 Review.

Table 3. 2004 On-site Operational Systems Review Results for UNICARE

Standard Number	Standard Description	Element Ratings Met/Partially Met/Not Met	Standard Rating
ER 1	Written policies regarding enrollee rights and protections	11/0/0	Met
ER 2	Information provided to enrollees upon enrollment and according to expected time frames	12/0/0	Met
ER 3	Information and language requirements	8/0/0	Met
ER 4	Protected health information	3/0/0	Met
ER 5	Emergency and post-stabilization services	5/0/0	Met
ER 6	Advanced directives	4/1/0	Partially Met
ER 7	Rehabilitation Act, ADA	3/0/0	Met
QA 1	Availability of services: network of appropriate providers	2/0/0	Met
QA 2	Availability of services: direct access to women's health specialist	1/0/0	Met
QA 3	Availability of services: second opinion	1/0/0	Met
QA 4	Availability of services: out of network	1/0/0	Met

Standard Number	Standard Description	Element Ratings Met/Partially Met/Not Met	Standard Rating
QA 5	Cultural considerations	1/0/0	Met
QA 6	Coordination and continuity of care	1/0/0	Met
QA 7	Coordination and continuity of care: additional services for enrollees with special health care needs	1/0/0	Met
QA 8	Direct access to specialists	2/0/0	Met
QA 9	Referrals and treatment plans	1/0/0	Met
QA 10	Primary care and coordination program	3/0/0	Met
QA 11	Coverage and authorization of services: processing of requests	9/0/0	Met
QA 12	Coverage and authorization of services-: notice of adverse action	1/0/0	Met
QA 13	Time frame for decisions: standard authorization decisions	1/0/0	Met
QA 14	Time frame for decisions: expedited authorization decisions	2/0/0	Met
QA 15	Provider selection: credentialing and recredentialing requirements	3/0/0	Met
QA 16	Provider selection: non-discrimination	1/0/0	Met
QA 17	Provider discrimination prohibited	1/0/0	Met
QA 18	Provider selection: excluded providers	1/0/0	Met
QA 19	Provider enrollment and disenrollment: requested by MCO	1/0/0	Met
QA 20	Provider enrollment and disenrollment: requested by the enrollee	2/0/0	Met
QA 21	Grievance systems	4/0/0	Met
QA 22	Subcontractual relationships and delegation	4/0/0	Met
QA 23	Practice guidelines	4/0/0	Met
QA 24	Dissemination of practice guidelines	1/0/0	Met
QA 25	Application of practice guidelines	1/0/0	Met
QA 26	Quality assessment and performance improvement program	3/0/0	Met
QA 27	Under/over utilization of services	1/0/0	Met
QA 28	Care furnished to enrollees with special health needs	1/0/0	Met
QA 29	Health/management information systems	5/0/0	Met
GS 1	Grievance system	8/0/0	Met
GS 2	Filing requirements: procedures	2/0/0	Met
GS 3	Notice of action	1/0/0	Met
GS 4	Content of notice action	6/0/0	Met

Standard Number	Standard Description	Element Ratings Met/Partially Met/Not Met	Standard Rating
GS 5	Record-keeping and reporting requirements	1/0/0	Met
GS 6	Handling of grievances and appeals: special requirements for appeals	6/0/0	Met
GS 7	Resolution and notification: grievances and appeals—standard resolution	2/0/0	Met
GS 8	Resolution and notification: grievances and appeals—expedited appeals	4/0/0	Met
GS 9	Resolution and notification	3/0/0	Met
GS 10	Requirements for state fair hearings	3/0/0	Met
GS 11	Effectuation of reversed appeal resolutions	2/0/0	Met

Scoring for the individual elements can be found in the Recommendations At-A-Glance Matrix, Appendix IA1, including recommendations for elements that did not achieve full compliance. Detailed findings for each of the 47 review standards by element can be found in Appendix IA2.

Conclusions and Recommendations

Conclusions

A total of 47 standards are evaluated as part of the operational systems review. Of the seven (7) Enrollee Rights standards, six (6) were met and only one (1) was partially met. All of the 29 Quality Assessment and Performance Improvement standards were met. All of the 11 Grievance Systems standards were fully met. None of the standards received a review determination of not met.

In the overall results UNICARE achieved a score of fully met for 46 of the standards evaluated as part of the review of Enrollee Rights, Quality Assessment, and Grievances systems. A review determination of partially met was achieved for the remaining standard. None of the 47 standards received a review determination of "Not Met" for the CY 2004 review.

Recommendations

The recommendations below are a summary of those included in the Detailed Findings section of this report (Appendix IA2). Implementation of these recommendations will facilitate full compliance in the next external quality review as well as serve to strengthen the MCO's program.

UNICARE scored a fully met in six (6) of the seven (7) Enrollee Rights standards. The remaining standard scored a partially met. It is recommended that UNICARE revise its policy, Second Medical Opinions, to include how it will communicate the availability of a no-cost second opinion and procedures to notify an enrollee how to request the second opinion.

UNICARE scored a fully met on all 29 Quality Assurance and Performance Improvement standards and all 11 Grievance System standards. Therefore, there are no specific recommendations for these two areas.

Appendix IA1

Recommendations At-A-Glance

Performance Rating – Virginia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	Partially Met	Not Met	Recommendations To Meet Element
ER1. The MCO has written policies regarding enrollee rights and protections and ensures that staff and affiliated providers take those rights into account when furnishing services					
1.1	Enrollee rights and responsibilities.	X			
1.2	Out of area coverage.	X			
1.3	Restrictions on enrollee's freedom of choice among network providers (431.51).	X			
1.4	Referrals to specialty care (422.113c).	X			
1.5	Enrollee notification – termination/change in benefits, services, or service delivery site.	X			
1.6	Procedures that instruct how to contact enrollee services and a description of the department and its functions.	X			
1.7	Procedures for grievances, appeals, and fair hearing procedures (438.10g, 438.400 – 438.424).	X			
1.8	List of non-English speaking languages spoken by which contracted provider.	X			
1.9	Provider-enrollee communications.	X			
1.10	Procedures for sharing information with enrollees – that they are not liable for payment in case of MCO insolvency.	X			
1.11	Enrollment/ Disenrollment.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	Partially Met	Not Met	Recommendations To Meet Element
ER2. Upon enrollment and according to expected timeframes, enrollees are provided a written statement that includes information on the following (see enrollee materials/brochures):					
2.1	Enrollee rights and responsibilities.				Exempt from the CY 2004 Review.
2.2	Enrollee identification cards – descriptions, how and when to use cards.	X			
2.3	All Benefits and services included and excluded as a condition of membership, including authorization requirements and any special benefit provisions that may apply to services obtained outside of the system.	X			
2.4	Procedures for obtaining out-of-area coverage.	X			
2.5	Procedures for restrictions on enrollee's freedom of choice among network providers.	X			
2.6	The MCO's policy on referrals for specialty care.	X			
2.7	Procedures for notifying enrollees affected by the termination or change in benefits, services, or service delivery site.				Exempt from the CY 2004 Review
2.8	Procedures on how to contact enrollee services and a description of the functions of enrollee services.	X			
2.9	Procedures for grievances, appeals, and fair hearing procedures, and the amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	Partially Met	Not Met	Recommendations To Meet Element
2.10	Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the enrollee's service area; include identification of providers that are not accepting new patients. This includes, at a minimum, information on primary care physicians, specialists, and hospitals.	X			
2.11	Procedures for provider-enrollee communications.	X			
2.12	Procedures for providing information on physician incentive plans for those enrollees who request it.	X			
2.13	Process for enrollment and disenrollment from MCO.	X			
ER3. Information and Language requirements (438.10)					
3.1	MCO written enrollee information is available in the prevalent, non-English languages (see DMAS contract) of its particular service area.	X			
3.2	Enrollee information is written in prose that is readable and easily understood.	X			
3.3	State requires Flesch-Kincaid readability of 40 or below (at or below 12th grade level).	X			

Performance Rating – Virginia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	Partially Met	Not Met	Recommendations To Meet Element
3.4	Enrollee vital documents must be translated into non-English languages regularly encountered in the eligible population. Examples of vital documents "Applications, consent forms, letters containing important information about participation in programs (such as a cover letter outlining conditions of participation in a Medicaid managed care program),notices advising LEP persons of the availability of free language assistance."	X			
3.5	MCO has provided written material in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.	X			
3.6	MCO has policies and procedures in place to make interpretation services available and free of charge to the each potential enrollee and enrollee. This applies to all non-English languages, not just those the State identifies as prevalent.	X			
3.7	MCO has policies and procedures in place to notify its enrollees that oral interpretation is available for any language and written information is available in prevalent languages; and how to access those services.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	**Partially Met**	**Not Met**	**Recommendations To Meet Element**
3.8	MCO has policies and procedures in place to inform enrollees and potential enrollees that information is available in alternative formats and how to access those formats.	**X**			
ER4. 42 C.F.R. 431, Subpart F, and the Code of Virginia, Title 2.1, Chapter 26, (the Privacy Protection Act of 1976) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).					
4.1	MCO has a confidentiality agreement in place with providers who have access to PHI.	**X**			
4.2	The Contractor shall implement and maintain appropriate safeguards to prevent the use and disclosure of protected health information (PHI).	**X**			
4.3	The Contractor shall make an individual's PHI available to the Department within thirty (30) days of an individual's request for such information as notified and in the format requested by the Department.	**X**			
ER5. Emergency and Post-Stabilization Services (438.114, 422.113c)					
5.1	MCO has policies and procedures in place that define emergency and post-stabilization situations, a description on what to do in an emergency, a telephone number and instructions for obtaining advice on getting care in an emergency, and that prior authorization is not needed.	**X**			
5.2	MCO has given enrollee information on how to utilize after-hours medical advice and enrollee services department.	**X**			

Performance Rating – Virginia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	**Partially Met**	**Not Met**	**Recommendations To Meet Element**
5.3	MCO has processes and procedures in place for obtaining emergency services, including use of the 911-telephone system or its local equivalent.	**X**			
5.4	MCO has provided enrollees with a description of how to obtain emergency transportation and other medically necessary transportation. (Medical HelpLine Access).	**X**			
5.5	MCO has provided enrollees with locations of settings that furnish emergency and post-stabilization services covered by MCO.	**X**			
ER6. Advanced Directives					
6.1	The MCO has provided adult enrollees with written information on advance directives, including a description of the applicable state law.	**X**			
6.2	MCO has requirements to allow enrollees to participate in treatment decisions/options.	**X**			
6.3	Procedures to communicate the risks, benefits, and consequences of treatment or non-treatment.	**X**			
6.4	MCO has policies and procedures to inform enrollees of direct access to women's health specialist within MCO network for routine and preventative care services, as well as a primary care provider.	**X**			

Performance Rating – Virginia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	**Partially Met**	**Not Met**	**Recommendations To Meet Element**
6.5	MCO has policies and procedures to inform enrollees that they may obtain a second opinion from a qualified health care professional within the network or outside the network if necessary, at no cost to enrollee.		X		UNICARE must revise the Second Medical Opinion policy to include how the MCO will communicate the availability of a no-cost second opinion and communicate the procedures for requesting a second opinion to enrollees. (It is noted that UNICARE provided a revised policy to include these procedures and this will be assessed for the CY 2005 review).
ER7. Rehabilitation Act, ADA					
7.1	MCO is in compliance with Federal and State laws regarding enrollee confidentiality.	X			
7.2	MCO has provided the enrollee with a description of their confidentiality policies.	X			
7.3	MCO has provided enrollee with information on how to obtain a copy of their medical record and how to request records from the MCO.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
QA1. 438.206 Availability of services (b)					
1.1	MCO has policies and procedures to maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract as evidenced by the following:	X			
1.2	MCO has policies that allow enrollees with disabling conditions, chronic illnesses, or children with special health care needs to request their PCP be a specialist.	X			
QA2. 438.206 Availability of services (b)(2)					
2.1	MCO has policies and procedures to inform enrollees of direct access to women's health specialist within MCO network for routine and preventive care services, as well as a primary care provider.	X			
QA3. 438.206 Availability of services (b)(3)					
3.1	MCO has policies and procedures to provide for a second opinion from a qualified health care professional within the network, or to provide for the enrollee to obtain one outside the network, at no cost to the enrollee.	X			
QA4. 438.206 Availability of services (b)(4)					
4.1	MCO has policies and procedures that provide necessary services out of network, if unable to cover necessary medical services required by enrollee.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
QA5. 438.206(c) (2) Cultural considerations.					
5.1	The MCO has policies and procedures to promote the delivery of services in a culturally competent manner to all enrollees including those with limited English proficiency and diverse cultural and ethnic backgrounds.	X			
QA6. 438.208 Coordination and continuity of care.					
6.1	MCO has policies and procedures in place to ensure coordinated care for all enrollees and provide particular attention to needs of enrollees with complex, serious, and/or disabling conditions.	X			
QA7. 438.208(c) 1-3 Coordination and continuity of care – additional services for enrollees with special health care needs					
7.1	The MCO makes a good faith effort to conduct an assessment of enrollees with complex, serious, and/or disabling conditions as identified and reported by the state, within 90 days receipt of notification of SSI children.	X			
QA8. 438.208(c) (4) Direct Access to specialists					
8.1	The MCO has policies and procedures that allow an enrollee with special needs to access a specialist as is appropriate for the condition and identified needs.	X			
8.2	Referral guidelines that demonstrate the conditions under which PCPs make arrangements for referrals to specialty care networks.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
QA9. 438.208 (d) (2) (ii – iii) Referrals and Treatment Plans					
9.1	The MCO has a mechanism in place for the development of a treatment plan by the specialist in consultation with the enrollee's PCP, with enrollee participation, and is approved in a timely manner.	X			
QA10. 438.208(e) Primary Care and Coordination Program					
10.1	MCO coordinates services furnished to enrollee with those of other MCOs, PHPs, or PAHPs to prevent duplication.	X			
10.2	Coordination of care across settings or transitions in care.	X			
10.3	MCO has policies and procedures to protect enrollee privacy while coordinating care.	X			
QA11. 438.210 (b) Coverage and Authorization of Services - Processing of requests					
11.1	The MCO has policies/procedures in place for processing requests for initial and continuing authorizations of services.	X			
11.2	MCO has policies and procedures in place to ensure that preauthorization requirements do not apply to emergency care, family planning services, preventative services, and basic prenatal care.	X			
11.3	The MCO monitors the application of review criteria for authorizations and takes corrective action to ensure consistent application.	X			
11.4	The MCO has policies and procedures in place for staff to consult with requesting providers when appropriate.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
11.5	If MCO delegates authorization decisions to subcontractors, the MCO has a mechanism to ensure that standards are met.	X			
11.6	Subcontractor's UM plan is submitted annually and upon revision.	X			
11.7	The MCO has policies and procedures in place that state any decision to deny service authorization requests or to authorize services in an amount, duration, or scope less than requested be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.	X			
11.8	MCO's service authorization decisions are completed within 2 days of receipt of all necessary information.	X			
11.9	MCO is prohibited from providing incentives for denial, limiting, or discontinuing medical services for enrollees.	X			
QA12. 438.210 (c) Coverage and authorization of services - Notice of adverse action.					
12.1	MCO notifies provider and gives written notice of any decision to deny a service authorization request or to authorize as requested.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
QA13. 438.210 (d) (1) Timeframe for decisions – Standard Authorization Decisions.					
13.1	MCO provides decision notice as expeditiously as enrollee's health condition requires, not to exceed 14 calendar days following receipt of request for service, with possible extension up to 14 additional calendar days if enrollee requests extension or MCO justifies a need for additional information.	X			
QA14. 438.210 (d) (2) Timeframe for decisions – Expedited Authorization Decisions					
14.1	The MCO has policies and procedures to make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than three (3) working days after receipt of the request for service.	X			
14.2	The MCO has policies and procedures relating to the extension time frames for expedited authorizations allowed under the state contract.	X			
QA15. 438.214 (b) Provider selection - Credentialing and recredentialing requirements.					
15.1	The MCO has written policies and procedures for selection and retention of providers.	X			
15.2	MCO recredentialing process takes into consideration the performance indicators obtained through QIP, UM program, Grievances and Appeals, and Enrollee satisfaction surveys.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
15.3	MCO's policies and procedures identify the mechanism for reporting serious quality deficiencies, resulting in suspension or termination of a practitioner, to the appropriate authorities. There is evidence that this process is in place. There is a comprehensive provider appeals process. A review of provider appeals indicates that the process is followed according to policy and procedures.	X			
QA16. 438.214 (c) Provider selection -Nondiscrimination.					
16.1	MCO provider selection policies and procedures do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.	X			
QA17. 438.12 (a, b) Provider discrimination prohibited					
17.1	For those individual or group providers who are declined, the MCO provides written notice with reason for decision.	X			
QA18. 438.214 (d) Provider Selection – Excluded Providers					
18.1	MCO has policies and procedures and adheres to ineligible provider or administrative entities requirements.	X			
QA19. 438.56 (b) Provider Enrollment and Disenrollment – requested by MCO					
19.1	MCO has policies and procedures that define processes MCO follows when requesting disenrollment, and that the request is in accordance to state contract.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
QA20. 438.56 (c) Provider Enrollment and Disenrollment – requested by enrollee					
20.1	MCO has policies and procedures in place for enrollees to request disenrollment.	X			
20.2	MCO has policies and procedures and adheres to timeframes established by state for notifying and transitioning enrollees to new PCPs after PCP disenrollment (30 calendar days for each).	X			
QA21. 438.228 Grievance systems					
21.1	MCO has a process for tracking requests for covered services that were denied.	X			
21.2	MCO has process for fair hearing notification.	X			
21.3	MCO has process for provider notification.	X			
21.4	MCO has process for enrollee notification and adheres to state timeframes.	X			
QA22. 438.230 Subcontractual relationships and delegation.					
22.1	MCO evaluates prospective subcontractor's ability to perform the activities to be delegated before delegation occurs.	X			
22.2	MCO has a written agreement that specifies the activities and report responsibilities designated to the subcontractor; and	X			
22.3	MCO has a process for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	**Partially Met**	**Not Met**	**Recommendations To Meet Element**
22.4	MCO performs an annual review of all subcontractors to evaluate performance and has a mechanism in place to report actions that seriously impact quality of care that may result in suspension/termination of licenses.	X			
QA23. 438.236 (a, b) Practice guidelines.					
23.1	The MCO has adopted practice guidelines that meet current quality standards and the following:				
a)	Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.	X			
b)	Consider the needs of enrollees.	X			
c)	Are adopted in consultation with contracting health care professionals and	X			
d)	Are reviewed and updated periodically, as appropriate.	X			
QA24. 438.236 (c) Dissemination of Practice Guidelines					
24.1	The MCO has policies and procedures for the dissemination of guidelines to all affected providers and, upon request, to enrollees and potential enrollees.	X			
QA25. 438.236 (d) Application of Practice Guidelines					
25.1	MCO decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the established guidelines.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
QA26. 438.240 Quality assessment and performance improvement program					
26.1	MCO has an ongoing quality assessment and performance improvement program for the services provided to this population.	X			
26.2	MCO is conducting 1 QIP to achieve, through ongoing measurement and interventions, demonstrable and sustained improvement in significant aspects of clinical and non-clinical care that can be expected to have a favorable effect on health outcomes and enrollee satisfaction.	X			
26.3	The MCO corrects significant systemic problems that come to its attention through internal surveillance, complaints, or other mechanisms.	X			
QA27. 438.240 (b) (2) Basic elements of QAPI program – under/over utilization of services					
27.1	MCO's QAPI program has mechanisms to detect both underutilization and over utilization of the MCO services.	X			
QA28. 438.240 (b) (3) Basic elements of QAPI program – care furnished to enrollees with special health needs					
28.1	MCO QAPI program has mechanisms to assess the quality of care and services provided to enrollees with special needs.	X			
QA29. 438.242 Health/Management Information systems.					
29.1	The MCO has information systems capable of furnishing timely, accurate, and complete information about the MCO program.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
29.2	The MCO information system is capable of: a. Accepting and processing enrollment. b. Reconciling reports of MCO enrollment/ Eligibility. c. Accepting and Processing provider claims and encounter data. d. Tracking provider network composition, access to services, grievances and appeals. e. Performing QI activities.	X			
29.3	Furnishing DMAS with timely, accurate, and complete clinical and administrative information.	X			
29.4	MCO ensures that data submitted by providers is accurate by: a. Verifying the accuracy and timeliness of reported data. b. Screening the data for completeness, logic, and consistency. c. Collecting the service information in standard formats for DMAS. d. Assigns unique identifiers to providers and requires that identifiers are used when providers submit data to the MCO.	X			
29.5	MCO uses encryption processes to send PHI over the internet.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart F Regulations: Grievance Systems					
		Met	Partially Met	Not Met	Recommendations To Meet Element
GS1. 438.402 (a, b) Grievance System					
1.1	MCO has written policies and procedures that describe the grievance and appeals process and how it operates.	X			
1.2	The definitions for grievances and appeals are consistent with those established by the state 7/03.	X			
1.3	Policies and procedures describe how the MCO intends to receive, track, review, and report all enrollee inquiries, grievances and appeals for the MCO program separately from other programs.	X			
1.4	Policies and procedures describe how MCO responds to grievances and appeals in a timely manner.	X			
1.5	Policies and procedures describe the documentation process and actions taken.	X			
1.6	Policies and procedures describe the aggregation and analysis of the data and use in QI.	X			
1.7	The procedures and any changes to the policies must be submitted to the DMAS annually.	X			
1.8	MCO provides information about grievance and appeals system to all providers and subcontractors.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart F Regulations: Grievance Systems					
		Met	**Partially Met**	**Not Met**	**Recommendations To Meet Element**
GS2. 438.402 (3) Filing Requirements- Procedures					
2.1	The MCO has grievance and appeal forms and provides written procedures to enrollees who wish to register written grievances or appeals.	X			
2.2	The MCO provides reasonable assistance in completing forms and taking other procedural steps including, but not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.	X			
GS3. 438.404 Notice of Action					
3.1	Notice of action is written according to language and format requirements set forth in GS 438.10 Information Requirements.	X			
S4. 438.404 (b) Content of Notice Action **Content of NOA explains all of the following:**					
4.1	The action taken and reasons for the action.	X			
4.2	The enrollee's right to file an appeal with MCO.	X			
4.3	The enrollee's right to request a State fair hearing.	X			
4.4	The procedures for exercising appeal rights.	X			
4.5	The circumstances under which expedited resolution is available and how to request an expedited resolution.	X			
4.6	The circumstances under which the enrollee has the right to request that benefits continue pending appeal resolution and the circumstances under which the enrollee may be required to pay the costs of services.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart F Regulations: Grievance Systems					
		Met	**Partially Met**	**Not Met**	**Recommendations To Meet Element**
GS5. 438.416 Record Keeping and reporting requirements					
5.1	The MCO maintains a record keeping and tracking system for inquiries, grievances, and appeals that includes a copy of the original grievance or appeal, the decision, and the nature of the decision.	X			
GS6. 438.406 Handling of grievances and appeals – special requirements for appeals					
6.1	MCO has policies that ensure that individuals who make decisions on grievances and appeals were not involved in previous levels of reviews or decision-making and are health care professionals with appropriate level of expertise in treating the enrollee's condition or disease.	X			
6.2	MCO provides that oral inquires seeking to appeal an action are treated as appeals and confirmed in writing, unless enrollee or provider request expedited resolution.	X			
6.3	MCO provides enrollee with reasonable opportunity to present evidence and allegation of the fact or law in person, as well as in writing.	X			
6.4	MCO informs enrollee of limited time available for cases of expedited resolution.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart F Regulations: Grievance Systems					
		Met	Partially Met	Not Met	Recommendations To Meet Element
6.5	MCO provides enrollee, representative, or legal representation of a deceased enrollee before and during the appeal process, to examine the enrollee case file, including medical records, considered during the appeal process.	X			
6.6	MCO continues benefits while appeal or state fair hearing is pending.	X			
GS7. 438.408 Resolution and Notification: Grievances and Appeals – Standard Resolution					
7.1	MCO responds in writing to standard appeals as expeditiously as enrollee's health condition requires- not exceeding 30 days from initial date of receipt of the appeal.	X			
7.2	In cases of appeals decisions not being rendered within 30 days, MCO provides written notice to enrollee.	X			
GS8. 438.408 Resolution and Notification: Grievances and Appeals – Expedited Appeals					
8.1	MCO has an expedited appeal process.	X			
8.2	The Contractor shall issue decisions for expedited appeals as expeditiously as the enrollee's health condition requires, not exceeding three (3) working days from the initial receipt of the appeal.	X			
8.3	MCO has a process for extension, and for notifying enrollee of reason for delay.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart F Regulations: Grievance Systems					
		Met	**Partially Met**	**Not Met**	**Recommendations To Meet Element**
8.4	MCO makes reasonable efforts to provide the enrollee with prompt verbal notice of any decisions that are not resolved wholly in favor of the enrollee and shall follow-up within two calendar days with a written notice of action.	X			
GS9. 438.408 (b -d) Resolution and notification					
9.1	MCO decisions on expedited appeals are in writing and include decision and date of decision.	X			
9.2	For decisions not wholly in favor of enrollee, the MCO provides the enrollee with the right to request a State fair hearing and how to do so, and the right to request to receive benefits while the hearing is pending and how to make the request, explaining that the enrollee may be held liable for the cost of those services if the hearing decision upholds the MCO.	X			
9.3	MCO gives enrollee oral notice of denial and follow up within 2 calendar days with written notice.	X			
GS10. 438.408 (c) Requirements for State Fair Hearings					
10.1	MCO educates enrollees on state's fair hearing process and that appeal must be in writing within 30 days of enrollee's receipt of notice of any action to deny, delay, terminate, or reduce services authorization request.	X			
10.2	MCO provides state with a summary describing basis for denial and for appeal.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart F Regulations: Grievance Systems					
		Met	**Partially Met**	**Not Met**	**Recommendations To Meet Element**
10.3	MCO faxes appeal summaries to state in expedited appeal cases.	**X**			
GS11. 438.410 Expedited resolution of appeals, GS. 438.424 Effectuation of reversed appeal resolutions					
11.1	The MCO must authorize the disputed services promptly and as expeditiously as the enrollee's health condition requires in cases where MCO or the state fair hearing department reverses a decision to deny, limit, or delay services, in cases where those services were not rendered.	**X**			
11.2	MCO provides reimbursement for those services in accordance with terms of final agreement by state's appeal division.	**X**			

Subpart C Regulations: Enrollee Rights and Protections

ER1. The MCO has written policies regarding enrollee rights and protections and ensures that staff and affiliated providers take those rights into account when furnishing services

Element 1.1 - Enrollee rights and responsibilities.
This element is met.

UNICARE Health Plan of Virginia Policies and Procedures, Enrollee Rights and Responsibilities, revised December 2004, includes the two required rights identified as missing in the 2003 external quality review (EQR): freedom from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation and free exercise of rights without adversely affecting the way the managed care organization (MCO) and its providers treat the enrollee. The third required right identified as missing was subsequently found to contain sufficient language to meet the requirements of the Medallion II contract modification dated July 1, 2003.

Element 1.2 - Out of area coverage.
This element is previously met - not reviewed.

Element 1.3 - Restrictions on enrollee's freedom of choice among network providers (431.51).
This element is met.

UNICARE Health Plan of Virginia Policies and Procedures, Family Planning Services-Access To, revised October 2003, outlines procedures to support enrollee access to any qualified family planning clinic or provider without a prior authorization even if that provider is not part of the UNICARE network.

Element 1.4 - Referrals to specialty care (422.113c).
This element is previously met - not reviewed.

Element 1.5 - Enrollee notification – termination/change in benefits, services or service delivery site.
This element is previously met - not reviewed.

Element 1.6 - Procedures that instruct how to contact enrollee services and a description of department and its functions.
This element is previously met - not reviewed.

Element 1.7 - Procedures for grievances, appeals, and fair hearing procedures (438.10g, 438.400 – 438.424).
This element is previously met - not reviewed.

Element 1.8 - List of non-English languages spoken by contracted providers.
This element is previously met - not reviewed.

Element 1.9 - Provider-enrollee communications.
This element is previously met - not reviewed.

Element 1.10 - Procedures for sharing information with enrollees – that they are not liable for payment in case of MCO insolvency.
This element is met.

UNICARE Health Plan of Virginia Policies and Procedures, MCO Insolvency, effective March 2005 includes procedures for notifying enrollees that they are not responsible in the event of MCO insolvency through the Enrollee Handbook and EOC. The EOC is provided to the enrollee upon enrollment and upon request.

Element 1.11 - Process for enrollment and disenrollment from MCO.
This element is previously met - not reviewed.

ER2. Upon enrollment and according to expected timeframes, enrollees are provided a written statement that includes information on the following (see enrollee materials/brochures):

Element 2.1 - Enrollee rights and responsibilities.
This element is exempt for the CY 2004 review.

The Department of Medical Assistance Services has exempted all MCOs from Evidence of Coverage/member handbook requirements for the 2004 review in response to delays experienced by some MCOs in receiving Bureau of Insurance approval of revisions to these documents. Review of this element will be for informational purposes only in assisting UNICARE in meeting this element in the next review.

The September 2004 draft of the Enrollee Handbook and EOC includes the two required rights identified as missing in the 2003 EQRO review: freedom from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation and free exercise of rights without adversely

affecting the way the MCO and its providers treat the enrollee. The third required right identified as missing was subsequently found to contain sufficient language to meet the requirements of the Medallion II contract modification dated July 1, 2003. The inclusion of these rights satisfies the requirement of this element.

Element 2.2 - Enrollee identification cards – descriptions and how and when to use cards.
This element is previously met - not reviewed.

Element 2.3 - All benefits and services included and excluded as a condition of membership, including authorization requirements and any special benefit provisions that may apply to services obtained outside of the system.
This element is previously met - not reviewed.

Element 2.4 - Procedures for obtaining out-of-area coverage.
This element is previously met - not reviewed.

Element 2.5 - Procedures for restrictions on enrollee's freedom of choice among network providers.
This element is previously met - not reviewed.

Element 2.6 - The MCO's policy on referrals for specialty care.
This element is previously met - not reviewed.

Element 2.7 Procedures for notifying enrollees affected by the termination or change in benefits, services, or service delivery site.
This element is exempt for the CY 2004 review.

The Department of Medical Assistance Services has exempted all MCOs from Evidence of Coverage/member handbook requirements for the 2004 review in response to delays experienced by some MCOs in receiving Bureau of Insurance approval of revisions to these documents. Review of this element will be for informational purposes only in assisting CareNet in meeting this element in the next review.

A July 2005 draft of the Member Handbook includes a section on Change in CareNet Benefits or Services advising enrollees that they will be notified in writing or through an update to the Member Handbook of any changes. Additionally, in the Your Rights section enrollees are advised that they will be notified at least 14 days before there are any program or site changes that affect them. This proposed revision satisfies the requirement of this element.

Element 2.8 - Procedures on how to contact enrollee services and a description of the functions of enrollee services.
This element is previously met - not reviewed.

Element 2.9 - Procedures for grievances, appeals, and fair hearing procedures, and the amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled.
This element is previously met - not reviewed.

Element 2.10 - Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the enrollee's service area including identification of providers that are not accepting new patients. This includes, at a minimum, information on primary care physicians, specialists, and hospitals.
This element is previously met - not reviewed.

Element 2.11 - Procedures for provider-enrollee communications.
This element is previously met - not reviewed.

Element 2.12 - Procedures for providing information on physician incentive plans for those enrollees who request it.
This element is previously met - not reviewed.

Element 2.13 - Process for enrollment and disenrollment from MCO.
This element is previously met - not reviewed.

ER3. Information and Language requirements (438.10)

Element 3.1 - MCO written enrollee information is available in the prevalent, non-English languages spoken in its particular service area (see DMAS contract).
This element is previously met - not reviewed.

Element 3.2 - Enrollee information is written in prose that is readable and easily understood.
This element is previously met - not reviewed.

Element 3.3 - State requires Flesch-Kincaid readability of 40 or higher (at or below 12th grade level).
This element is previously met - not reviewed.

Element 3.4 - Enrollee vital documents must be translated into non-English languages regularly encountered in the eligible population. Examples of vital documents include: "Applications, consent forms, letters containing important information about participation in programs (such as a cover letter outlining conditions of participation in a Medicaid managed care program), ...notices advising people with limited English proficiency of the availability of free language assistance."
This element is previously met - not reviewed.

Element 3.5 - MCO has provided written material in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.
This element is previously met - not reviewed.

Element 3.6 - MCO has policies and procedures in place to make interpretation services available and free of charge to each potential enrollee and enrollee. This applies to all non-English languages, not just those the state identifies as prevalent.
This element is previously met - not reviewed.

Element 3.7 - MCO has policies and procedures in place to notify its enrollees that oral interpretation is available for any language and written information is available in prevalent languages; and how to access those services.
This element is previously met - not reviewed.

Element 3.8 - MCO has policies and procedures in place to inform enrollees and potential enrollees that information is available in alternative formats and how to access those formats.
This element is previously met - not reviewed.

ER4. 42 C.F.R. 431, Subpart F, and the Code of Virginia, Title 2.1, Chapter 26, (the Privacy Protection Act of 1976) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Element 4.1 - MCO has a confidentiality agreement in place with providers who have access to PHI.
This element is previously met - not reviewed.

Element 4.2 - The Contractor shall implement and maintain appropriate safeguards to prevent the use and disclosure of protected health information (PHI)
This element is previously met - not reviewed.

Element 4.3 - The Contractor shall make an individual's PHI available to the Department within 30 days of an individual's request for such information as notified and in the format requested by the Department.
This element is previously met - not reviewed.

ER5. Emergency and Post-Stabilization Services (438.114, 422.113c)

Element 5.1 - MCO has policies and procedures in place that define emergency and post-stabilization situations, a description on what to do in an emergency, a telephone number and instructions for obtaining advice on getting care in an emergency, and that prior authorization is not needed.
This element is previously met - not reviewed.

Element 5.2 - MCO has given enrollee information on how to utilize after-hours medical advice and enrollee services department.
This element is previously met - not reviewed.

Element 5.3 - MCO has processes and procedures in place for obtaining emergency services, including use of the 911-telephone system or its local equivalent.
This element is previously met - not reviewed.

Element 5.4 - MCO has provided enrollees with a description of how to obtain emergency transportation and other medical necessary transportation (Medical HelpLine Access).
This element is previously met - not reviewed.

Element 5.5 - MCO has provided enrollees with locations of settings that furnish emergency and post-stabilization services covered by MCO.
This element is met.

UNICARE's Provider Directory for Medallion II enrollees, May 2005 version, includes emergency and post-stabilization, if appropriate under the services provided for each of the hospitals listed.

ER6. Advanced Directives

Element 6.1 - The MCO has provided adult enrollees with written information on advance directives, including a description of the applicable state law.
This element is previously met - not reviewed.

Element 6.2 - MCO has requirements to allow enrollees to participate in treatment decisions/options.
This element is previously met - not reviewed.

Element 6.3 - Procedures to communicate the risks, benefits, and consequences of treatment or non-treatment.
This element is previously met - not reviewed.

Element 6.4 - MCO has policies and procedures to inform enrollees of direct access to women's health specialist within MCO network for routine and preventative care services, as well as a primary care provider.
This element is previously met - not reviewed.

Element 6.5 - MCO has policies and procedures to inform enrollees that they may obtain a second opinion from a qualified health care professional within the network or outside the network if necessary, at no cost to enrollee.
This element is partially met.

UNICARE Health Plan of Virginia Policies and Procedures, Second Medical Opinion, effective January 2005, outlines procedures for providing coverage for second opinions at the request of either an enrollee or provider. There is no mention in the policy, however, as to how UNICARE will inform enrollees about the availability of a no cost second opinion and procedures for requesting one. The September 2004 draft of the Enrollee Handbook and EOC does include a detailed section on Getting A Second Medical Opinion. This section advises the enrollee of the availability of a no cost second opinion from a qualified health care provider and procedures for requesting one. Contact numbers are provided for additional information as well as enrollee appeal rights if they are denied a second opinion.

Recommendation:
In order to receive a finding of met in the next EQRO review it is recommended that UNICARE revise the above policy to include how it will communicate the availability of a no cost second opinion and procedures for requesting one to enrollees. Subsequent to the review UNICARE did submit a revised policy to include these procedures that will be reviewed in 2006.

ER7. Rehabilitation Act, ADA

Element 7.1 - MCO complies with Federal and State laws regarding enrollee confidentiality.
This element is previously met - not reviewed.

Element 7.2 - MCO has provided the enrollee with a description of their confidentiality policies.
This element is previously met - not reviewed.

Element 7.3 - MCO has provided enrollee with information on how to obtain a copy of their medical record and how to request records from the MCO.
This element is previously met - not reviewed.

Subpart D Regulations: Quality Assessment and Performance Improvement

QA1. 438.206 Availability of services (b).

Element 1.1 - MCO has policies and procedures to maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract.
This element is previously met - not reviewed.

Element 1.2 - MCO has policies that allow enrollees with disabling conditions, chronic illnesses, or children with special health care needs to request their PCP be a specialist.
This element is previously met - not reviewed.

QA2. 438.206 Availability of services (b)(2).

Element 2.1 - MCO has policies and procedures to inform enrollees of direct access to women's health specialist within MCO network for routine and preventative care services, as well as a primary care provider.
This element is previously met - not reviewed.

QA3. 438.206 Availability of services (b)(3).

Element 3.1 - MCO has policies and procedures to provide for a second opinion from a qualified health care professional within the network, or to provide for the enrollee to obtain one outside the network, at no cost to the enrollee.
This element is met.

UNICARE Health Plan of Virginia Policies and Procedures, Second Medical Opinion, effective January 2005, outlines the availability of a second opinion requested by either an enrollee or provider for a number of medical categories. Procedures also address the requirement that the second opinion be provided by an appropriately qualified health care professional within the plan network. Provisions are made for second opinions from a qualified out of network provider in cases where there is no provider in the network that meets the above specified qualifications. There is no mention in the policy that the second opinion will be provided at no cost to the enrollee, however, the 2005 UM Program Description includes the required language.

Recommendation:

It is recomm4nded that UNICARE revise the above policy to include the availability of a second opinion at no cost to the enrollee. Subsequent to the review UNICARE submitted a revised policy that contains this language and will be reviewed in the 2006 review.

QA4. 438.206 Availability of services (b)(4)

Element 4.1 - MCO has policies and procedures that provide necessary services out of network, if unable to cover necessary medical services required by enrollee.

This element is previously met - not reviewed.

QA5. 438.206(c)(2) Cultural considerations.

Element 5.1 - The MCO has policies and procedures to promote the delivery of services in a culturally competent manner to all enrollees including those with limited English proficiency and diverse cultural and ethnic backgrounds.

This element is previously met - not reviewed.

QA6. 438.208 Coordination and continuity of care.

Element 6.1 - MCO has policies and procedures in place to ensure coordinated care for all enrollees and provide particular attention to needs of enrollees with complex, serious, and/or disabling conditions.

This element is previously met - not reviewed.

QA7. 438.208(c) 1-3 Additional services for enrollees with special health care needs.

Element 7.1 - The MCO makes a good faith effort to conduct an assessment of enrollees with complex, serious, and/or disabling conditions as identified and reported by the state, within 90 days receipt of notification of SSI children.

This element is previously met - not reviewed.

QA8. 438.208(c) (4) Direct access to specialists.

Element 8.1 - The MCO has policies and procedures that allow an enrollee with special needs to access a specialist as is appropriate for the condition and identified needs.
This element is previously met - not reviewed.

Element 8.2 - Referral guidelines that demonstrate the conditions under which PCPs arrange for referrals to specialty care networks.
This element is previously met - not reviewed.

QA9. 438.208 (d) (2) (ii – iii) Referrals and treatment plans.

Element 9.1 - The MCO has a mechanism in place for the development of a treatment plan by the specialist in consultation with the enrollee's PCP, with enrollee participation, and is approved in a timely manner.
This element is previously met - not reviewed.

QA10. 438.208(e) Primary care and coordination program.

Element 10.1 - MCO coordinates services furnished to enrollee with those of other MCOs, PIHP, PAHP to prevent duplication.
This element is previously met - not reviewed.

Element 10.2 - Coordination of care across settings or transitions in care.
This element is previously met - not reviewed.

Element 10.3 - MCO has policies and procedures to protect enrollee privacy while coordinating care.
This element is previously met - not reviewed.

QA11. 438.210 (b) Coverage and authorization of services - processing of requests.

Element 11.1 - The MCO has policies/procedures in place for processing requests for initial and continuing authorizations of services.
This element is previously met - not reviewed.

Element 11.2 - MCO has policies/procedures in place to ensure that preauthorization requirements do not apply to emergency care, family planning services, preventive services and basic prenatal care.
This element is previously met - not reviewed.

Element 11.3 - The MCO monitors the application of review criteria for authorizations and takes corrective action to ensure consistent application.
This element is met.

UNICARE Health Plan of Virginia Policies and Procedures Physician Review Audits- Process and Inter-rater was revised January 2005 to include the responsibility of the Medical Director for tracking and trending physician review audit results and reporting these results to the Utilization Management Committee (UMC) for approval, discussion, assessment, and identification of areas of opportunity.

UNICARE has submitted UMC meeting minutes from the last quarter of 2004 that demonstrate compliance with required reporting of quarterly process audits and annual inter-rater reliability assessments for physician and non-physician review staff. Reporting of quarterly physician process audit results, however, has a considerable lag time. For example, second quarter results were not reported until December as identified below. Review of UMC minutes from October 21, 2004 evidenced presentation of the revised 2004 Spring Peer Clinical Reviewers Inter-rater Reliability report. The UMC minutes of November 18, 2004 documented a comprehensive report of the third quarter 2004 UM process audit involving UM and Case Management nurses. The December 16, 2004 UMC minutes included a report on the annual inter-rater reliability assessments of UM and Case Management nursing staff. Twenty-seven nurses participated in the outpatient assessments resulting in a total score of 73%, which was significantly below the performance threshold of 90%. Thirty-seven nurses participated in the inpatient assessment with an average score of 93%, which was above the performance threshold of 90%. Issues identified and recommendations for follow-up were listed. An update on the annual physician inter-rater reliability assessments was also provided. It was reported that the Medical Director was meeting with the Physician Advisors individually in December to discuss each of their evaluations. A formal written report of the physician inter-rater reliability results was to be presented at the next UMC. Additionally, a report was presented on the Peer Clinical Reviews from the second quarter 2004 audit. Results revealed that the 90% goal was not achieved in two areas with associated recommendations for improvement.

Recommendation:
It is recommended that the quarterly physician process audits results be reported in the following quarter rather than two quarters later. This allows for more timely feedback and recommendations from the UMC.

Element 11.4 - The MCO has policies/procedures in place for staff to consult with requesting providers when appropriate.
This element is previously met - not reviewed.

Element 11.5 - If MCO delegates authorization decisions to subcontractors, the MCO has a mechanism to ensure that standards are met.
This element is previously met - not reviewed.

Element 11.6 - Subcontractor's utilization management plan is submitted annually and upon revision.
This element is previously met - not reviewed.

Element 11.7 - The MCO has policies/procedures in place that state any decision to deny service authorization requests or to authorize services in an amount, duration, or scope less than requested be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.
This element is previously met - not reviewed.

Element 11.8 - MCO's service authorization decisions are completed within 2 days of receipt of all necessary information.
This element is previously met - not reviewed.

Element 11.9 - MCO is prohibited from providing incentives for denial, limiting, or discontinuing medical services for enrollees.
This element is previously met - not reviewed.

QA12. 438.210 (c) Coverage and authorization of services - notice of adverse action.

Element 12.1 - MCO notifies provider and gives written notice of any decision to deny a service authorization request or to authorize as requested.
This element is previously met - not reviewed.

QA13. 438.210 (d) (1) Timeframe for decisions – standard authorization decisions.

Element 13.1 - MCO provides decision notice as expeditiously as enrollee's health condition requires, not exceeding 14 calendar days following receipt of request for service, with possible extension up to 14 additional calendar days if enrollee requests extension or MCO justifies a need for additional information.
This element is previously met - not reviewed.

QA14. 438.210 (d) (2) Timeframe for decisions – expedited authorization decisions.

Element 14.1 - The MCO has policies/procedures to make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than three working days after receipt of the request for service.
This element is previously met - not reviewed.

Element 14.2 - The MCO has policies/procedures relating to the extension time frames for expedited authorizations allowed under the state contract.
This element is previously met - not reviewed.

QA15. 438.214 (b) Provider selection - credentialing and recredentialing requirements.

Element 15.1 - The MCO has written policies/procedures for selection and retention of providers using 2003 NCQA guidelines.
This element is previously met - not reviewed.

Element 15.2 - MCO recredentialing process takes into consideration the performance indicators obtained through quality improvement projects (QIPs), utilization management program, grievances and appeals, and enrollee satisfaction surveys.
This element is previously met - not reviewed.

Element 15.3 - MCO's policies and procedures identify the mechanism for reporting serious quality deficiencies, resulting in suspension or termination of a practitioner, to the appropriate authorities. There is evidence that this process is in place. There is a comprehensive provider appeals process. A review of provider appeals indicates that the process is followed according to policy and procedures.
This element is previously met - not reviewed.

QA16. 438.214 (c) Provider selection -nondiscrimination.

Element 16.1 - MCO provider selection policies and procedures do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.
This element is previously met - not reviewed.

QA17. 438.12 (a, b) Provider discrimination prohibited.

Element 17.1 - For those individual or group providers who are declined, the MCO provides written notice with reason for decision.
This element is previously met - not reviewed.

QA18. 438.214 (d) Provider Selection – excluded providers.

Element 18.1 - MCO has policies/procedures and adheres to ineligible provider or administrative entities requirements set forth in K. Provider Relations.
This element is previously met - not reviewed.

QA19. 438.56 (b) Provider enrollment and disenrollment – requested by MCO.

Element 19.1 - MCO has policies/procedures that define processes MCO follows when requesting disenrollment, and that the request is in accordance to state contract.
This element is previously met - not reviewed.

QA20. 438.56 (c) Provider enrollment and disenrollment – requested by enrollee.

Element 20.1 - MCO has policies/procedures in place for enrollees to request disenrollment.
This element is previously met - not reviewed.

Element 20.2 - MCO has policies/procedures and adheres to time frames established by state for notifying and transitioning enrollees to new PCPs after PCP disenrollment (30 calendar days for each).
This element is previously met - not reviewed.

QA21. 438.228 Grievance systems.

Element 21.1 - MCO has a process for tracking requests for covered services that were denied
This element is previously met - not reviewed.

Element 21.2 - MCO has process for fair hearing notification.
This element is previously met - not reviewed.

Element 21.3 - MCO has process for provider notification.
This element is previously met - not reviewed.

Element 21.4 - MCO has process for enrollee notification and adheres to state time frames.
This element is previously met - not reviewed.

QA22. 438.230 Subcontractual relationships and delegation.

Element 22.1 - MCO evaluates prospective subcontractor's ability to perform the activities to be delegated before delegation occurs.
This element is previously met - not reviewed.

Element 22.2 - MCO has a written agreement that specifies the activities and report responsibilities designated to the subcontractor.
This element is previously met - not reviewed.

Element 22.3 - MCO has a process for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.
This element is previously met - not reviewed

Element 22.4 - MCO performs an annual review of all subcontractors to evaluate performance and has a mechanism in place to report actions that seriously impact quality of care that may result in suspension/termination of licenses.
This element is previously met - not reviewed.

QA23. 438.236 (a, b) Practice guidelines.

Element 23.1 - The MCO has adopted practice guidelines that meet current NCQA standards and the following:

a) Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.
This component is previously met - not reviewed.

b) Consider the needs of the enrollees.
This component is previously met - not reviewed.

c) Are adopted in consultation with contracting health care professionals.
This component is previously met - not reviewed.

d) Are reviewed and updated periodically, as appropriate.
This component is previously met - not reviewed.

QA24. 438.236 (c) Dissemination of practice guidelines.

Element 24.1 - The MCO has policies/procedures for the dissemination of guidelines to all affected providers and, upon request, to enrollees and potential enrollees.
This element is previously met - not reviewed.

QA25. 438.236 (d) Application of practice guidelines.

Element 25.1 - MCO decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the established guidelines.
This element is previously met - not reviewed.

QA26. 438.240 Quality assessment and performance improvement program.

Element 26.1 - MCO has an ongoing quality assessment and performance improvement program for the services provided to this population.
This element is previously met - not reviewed.

Element 26.2 - MCO is conducting 1 QIP to achieve, through ongoing measurement and interventions, demonstrable and sustained improvement in significant aspects of clinical and non-clinical care that can be expected to have a favorable effect on health outcomes and enrollee satisfaction.
This element is previously met - not reviewed.

Element 26.3 - The MCO corrects significant systemic problems that come to its attention through internal surveillance, complaints, or other mechanisms.
This element is previously met - not reviewed.

QA27. 438.240 (b) (2) Basic elements of QAPI program – under/over utilization of services.

Element 27.1 - MCO's QAPI program has mechanisms to detect both underutilization and overutilization of the Medallion II services.
This element is met.

The November 18, 2004 UMC minutes documented presentation of the Over/Under Utilization Report which provided an evaluation of the results for the following measures: acute medical care inpatient discharges per 1000 member months, ambulatory care ER visits per 1000 member months, frequency of selected procedures (Cesarean sections per 1000 member months), and member satisfaction relating to CAHPS question #26, waiting for plan approval. The Quality Improvement Committee minutes of February 16, 2005 documented a report from the UMC highlighting key accomplishments from the December 16, 2004 meeting to include presentation of the updated 2004 over-under utilization analysis.

QA28. 438.240 (b) (3) Basic elements of QAPI program – care furnished to enrollees with special health needs.

Element 28.1 - MCO QAPI program has mechanisms to assess the quality of care and services provided to enrollees with special needs.
This element is previously met - not reviewed.

QA29. 438.242 Health/management information systems.

Element 29.1 - The MCO has information systems capable of furnishing timely, accurate, and complete information about the Medallion II program.
This element is previously met - not reviewed.

Element 29.2 - The MCO information system is capable meeting requirements.
This element is previously met - not reviewed.

Element 29.3 - Furnishing DMAS with timely, accurate and complete clinical and administrative information.
This element is previously met - not reviewed.

Element 29.4 - MCO ensures that data submitted by providers are accurate by meeting requirements.
This element is previously met - not reviewed.

Element 29.5 - MCO uses encryption processes to send PHI over the Internet
This element is previously met - not reviewed.

Subpart F Regulations: Grievance Systems

GS1. 438.402 (a, b) Grievance system.

Element 1.1 - MCO has written policies and procedures that describe the grievance and appeals process and how it operates.
This element is previously met - not reviewed.

Element 1.2 - The definitions for grievances and appeals are consistent with those established by the state in July 2003.
This element is previously met - not reviewed.

Element 1.3 - Policies/procedures describe how the MCO intends to receive, track, review, and report all enrollee inquiries, grievances and appeals for the Medallion II program separately from the commercial program.
This element is previously met - not reviewed.

Element 1.4 - Policies/procedures describe how MCO responds to grievances and appeals in a timely manner.
This element is previously met - not reviewed.

Element 1.5 - Policies/procedures describe the documentation process and actions taken.
This element is previously met - not reviewed.

Element 1.6 - Policies/procedures describe the aggregation and analysis of the data and use in quality improvement.
This element is previously met - not reviewed.

Element 1.7 - The procedures and any changes to the policies/procedures must be submitted to the DMAS annually.
This element is previously met - not reviewed.

Element 1.8 - MCO provides information about grievance and appeals system to all providers and subcontractors.
This element is previously met - not reviewed.

GS2. 438.402 (3) Filing requirements- procedures.

Element 2.1 - The MCO has grievance and appeal forms and provides written procedures to enrollees who wish to register written grievances or appeals.
This element is previously met - not reviewed.

Element 2.2 - The MCO provides reasonable assistance in completing forms and taking other procedural steps including, but not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.
This element is previously met - not reviewed.

GS3. 438.404 Notice of action.

Element 3.1 - Notice of action is written according to language and format requirements set forth in **GS.** 438.10 Information Requirements.
This element is previously met - not reviewed.

GS4. 438.404 (b) Content of notice of action.
Content of NOA explains all of the following:

Element 4.1 - The action taken and reasons for the action.
This element is previously met - not reviewed.

Element 4.2 - The enrollee's right to file an appeal with MCO
This element is previously met - not reviewed.

Element 4.3 - The enrollee's right to request a state fair hearing.
This element is previously met - not reviewed.

Element 4.4 - The procedures for exercising appeal rights.
This element is previously met - not reviewed.

Element 4.5 - The circumstances under which expedited resolution is available and how to request an expedited resolution.
This element is previously met - not reviewed.

Element 4.6 - The circumstances under which the enrollee has the right to request that benefits continue pending appeal resolution and the circumstances under which the enrollee may be required to pay the costs of services.
This element is met.

Draft language to be added to the notice of action letters was provided that advises enrollees of the right to benefit continuation during their appeal process if the listed criteria are met. The notice of action also addresses enrollee liability for the cost of those services furnished while the appeal is pending if the appeal is ultimately denied. UNICARE has advised of its intent to forward this draft language to the Department of Medical Assistance Services (DMAS) for review and approval.

GS5. 438.416 Record keeping and reporting requirements.

Element 5.1 - The MCO maintains a record keeping and tracking system for inquiries, grievances, and appeals that includes a copy of the original grievance or appeal, the decision, and the nature of the decision.
This element is previously met - not reviewed.

GS6. 438.406 Handling of grievances and appeals – special requirements for appeals.

Element 6.1 - MCO has policies that ensure that individuals who make decisions on grievances and appeals were not involved in previous levels of reviews or decision-making and are health care professionals with appropriate level of expertise in treating enrollee's condition or disease.
This element is previously met - not reviewed.

Element 6.2 - MCO provides that oral inquires seeking to appeal an action are treated as appeals and confirmed in writing, unless enrollee or provider request expedited resolution.
This element is previously met - not reviewed.

Element 6.3 MCO provides enrollee with reasonable opportunity to present evidence and allegation of the fact or law in person, as well as in writing.
This element is previously met - not reviewed.

Element 6.4 - MCO informs enrollee of limited time available for cases of expedited resolution.
This element is previously met - not reviewed.

Element 6.5 - MCO provides enrollee, representative, or legal representation of a deceased enrollee before and during the appeal process, to examine the enrollee case file, including medical records, considered during the appeal process.
This element is previously met - not reviewed.

Element 6.6 - MCO continues benefits while appeal or state fair hearing is pending.
This element is met.

UNICARE Health Plan of Virginia Policies and Procedures, Enrollee Appeals, Standard, was revised March 2005, to address the requirement for enrollee benefit continuation while an appeal or state fair hearing is pending if all of the listed criteria is met. This same language is included in the March revision of the UNICARE Health Plan of Virginia Policies and Procedures, Enrollee Appeals, Expedited and in the Fair Hearings for the Medicaid Program policy created in January 2005. The September 2004 draft of the Member Handbook and Evidence of Coverage (EOC) informs enrollees of this right.

GS7. 438.408 Resolution and notification: grievances and appeals – standard resolution.

Element 7.1 - MCO responds in writing to standard appeals as expeditiously as enrollee's health condition requires-not exceeding 30 days from initial date of receipt of the appeal.
This element is previously met - not reviewed.

Element 7.2 - In cases of appeal decisions not being rendered within 30 days, MCO provides written notice to enrollee.
This element is previously met - not reviewed.

GS8. 438.408 Resolution and notification: grievances and appeals – expedited appeals.

Element 8.1 - MCO has an expedited appeal process.
This element is previously met - not reviewed.

Element 8.2 - The Contractor shall issue decisions for expedited appeals as expeditiously as the enrollee's health condition requires, not exceeding three working days from the initial receipt of the appeal.
This element is previously met - not reviewed.

Element 8.3 - MCO has a process for extension, and for notifying enrollees of reason for delay.
This element is met.

UNICARE Health Plan of Virginia Policies and Procedures, Enrollee Appeals, Expedited, was revised March 2005 to include procedures in the event an extension of the time frame for expedited appeal decisions is required. Specifically, the policy provides for an extension of the 72 hour time frame for issuing an expedited appeal decision by up to an additional 14 calendar days if the enrollee requests the extension or if UNICARE provides evidence satisfactory to the DMAS that a delay in rendering the decision is in the enrollee's interest. For any extension not requested by the enrollee UNICARE is to provide written notice to the enrollee of the reason for the delay. The September 2004 draft of the Member Handbook and EOC includes language informing enrollees about extension time frames for expedited appeals and the process of enrollee notification.

Element 8.4 - MCO makes reasonable efforts to provide the enrollee with prompt verbal notice of any decisions that are not resolved wholly in favor of the enrollee and shall follow-up within two calendar days with a written notice of action.
This element is previously met - not reviewed.

GS9. 438.408 (b-d) Resolution and notification.

Element 9.1 - Decisions by the MCO to expedite appeals are in writing and include decision and date of decision.
This element is previously met - not reviewed.

Element 9.2 - For decisions not wholly in favor of enrollee, the MCO provides the enrollee with the right to request a state fair hearing and how to do so, and the right to request to receive benefits while the hearing is pending and how to make the request, explaining that the enrollee may be held liable for the cost of those services if the hearing decision upholds the MCO.
This element is met.

UNICARE Health Plan of Virginia Policies and Procedures, Enrollee Appeals, Standard, was revised March 2005, to address the requirement for language in the notice of the appeal decision for appeals not resolved wholly in favor of the enrollee that the enrollee may be held liable for the cost of continuation of benefits upon request while the state fair hearing is pending if the hearing decision upholds UNICARE's action. This same language is included in the March revision of the UNICARE Health Plan of Virginia Policies and Procedures, Enrollee Appeals, Expedited.

Element 9.3 - MCO gives enrollee oral notice of denial and follow up within 2 calendar days with written notice.
This element is met.

UNICARE Health Plan of Virginia Policies and Procedures, Enrollee Appeals, Expedited, was revised March 2005 to include required language for providing the enrollee with prompt verbal notice, within reasonable efforts, of any decision that is not resolved wholly in favor of the enrollee and to follow up within two calendar days with a written notice of action.

GS10. 438.408 (c) Requirements for state fair hearings.

Element 10.1 - MCO educates enrollees on state's fair hearing process and that appeal must be in writing within 30 days of enrollee's receipt of notice of any action to deny, delay, terminate, or reduce services authorization request.
This element is previously met - not reviewed.

Element 10.2 - MCO provides state with a summary describing basis for denial and for appeal.
This element is previously met - not reviewed.

Element 10.3 - MCO faxes appeal summaries to state in expedited appeal cases.
This element is met.

UNICARE Health Plan of Virginia Policies and Procedures, Enrollee Appeals, Expedited, was revised March 2005 to include the required MCO procedure for faxing the DMAS an appeal summary describing the basis for the denial. The appeal summary is to be faxed to DMAS and faxed or overnight mailed to the enrollee as expeditiously as the enrollee's health condition requires but no later than four business hours after DMAS informs UNICARE of the expedited appeal.

GS11. 438.410 Expedited resolution of appeals, GS. 438.424 effectuation of reversed appeal resolutions.

Element 11.1 - The MCO must authorize the disputed services promptly and as expeditiously as the enrollee's health condition requires in cases where MCO or State Fair Hearing Department reverses a decision to deny, limit, or delay services, in cases where those services were not rendered.
This element is met.

UNICARE Health Plan of Virginia Policies and Procedures, Enrollee Appeals, Standard, was revised March 2005, to include required language that if the UNICARE or the State Fair Hearing decision reverses a decision to deny, limit, or delay services, where such services were not rendered while the appeal was pending, UNICARE will authorize the disputed services promptly and as expeditiously as the enrollee's health condition requires. This same language is included in the March revision of the UNICARE Health Plan of Virginia Policies and Procedures, Enrollee Appeals, Expedited.

Element 11.2 - MCO provides reimbursement for those services in accordance with terms of final agreement by state's appeal division.
This element is met.

UNICARE Health Plan of Virginia Policies and Procedures, Enrollee Appeals, Standard, was revised March 2005, to include required language that in the event that services were continued while the appeal was pending UNICARE will provide reimbursement for those services in accordance with the terms of the final decision rendered. This same language is included in the March revision of the UNICARE Health Plan of Virginia Policies and Procedures, Enrollee Appeals, Expedited.

Summary of Documents Reviewed		
Element	**Document**	**Date**
ER 1	UNICARE Health Plan of Virginia Policies and Procedures: Policy #COXX_104 Enrollee Rights and Responsibilities	12/09/2004 revised
	UNICARE Health Plan of Virginia Policies and Procedures: Policy #UMXX_020 Family Planning Services-Access to	10/14/2003 revised
	UNICARE Health Plan of Virginia Policies and Procedures: Policy #COXX_111 MCO Insolvency	03/23/2005 effective
ER 2	Enrollee Handbook and Evidence of Coverage (draft)	09/2004
ER 5	Provider Directory for Medallion II	May 2005
ER 6	UNICARE Health Plan of Virginia Policies and Procedures: Policy #UMXX_082 Second Medical Opinion	01/14/2005 effective
	Enrollee Handbook and Evidence of Coverage (draft)	09/2004
QA 3	UNICARE Health Plan of Virginia Policies and Procedures: Policy #UMXX_082 Second Medical Opinion	01/14/2005 effective
	2005 UNICARE UM Program Description	12/16/2004
QA 11	UNICARE Health Plan of Virginia Policies and Procedures: Policy #UMXX_078 Physician Review Audits- Process and Inter-rater	01/07/2005 revised
	Utilization Management Committee Meeting Minutes	10/21/2004, 11/18/2004, 12/16/2004
QA 27	UNICARE Health Plan of Virginia 2004 Assessment of Potential Under and Over-Utilization Based on 2004 Reporting Year (2003 Measurement Year) HEDIS Data	04/27/2005
	Utilization Management Committee Meeting Minutes	11/18/2004
	Quality Improvement Committee Minutes	02/16/2005
GS 4	Notice of Action: Resolution to Appeal Upheld- Lack of Medical Information (draft)	05/2003
GS 6	UNICARE Health Plan of Virginia Policies and Procedures: Policy #UMXX_051 Enrollee Appeals Standard	03/24/2005 revised
	UNICARE Health Plan of Virginia Policies and Procedures: Policy #UMXX_052 Enrollee Appeals- Expedited	03/25/2005 revised
	UNICARE Health Plan of Virginia Policies and Procedures: Policy #UMXX_029 Fair Hearings for the Medicaid Program	01/14/2005
	Enrollee Handbook and Evidence of Coverage (draft)	09/2004
GS 8	UNICARE Health Plan of Virginia Policies and Procedures: Policy #UMXX_052 Enrollee Appeals- Expedited	03/25/2005 revised
	Enrollee Handbook and Evidence of Coverage (draft)	09/2004
GS 9	UNICARE Health Plan of Virginia Policies and Procedures: Policy #UMXX_051 Enrollee Appeals Standard	03/24/2005 revised
	UNICARE Health Plan of Virginia Policies and Procedures: Policy #UMXX_052 Enrollee Appeals- Expedited	03/25/2005 revised
GS 10	UNICARE Health Plan of Virginia Policies and Procedures: Policy #UMXX_052 Enrollee Appeals- Expedited	03/25/2005 revised
GS 11	UNICARE Health Plan of Virginia Policies and Procedures: Policy #UMXX_051 Enrollee Appeals Standard	03/24/2005 revised
	UNICARE Health Plan of Virginia Policies and Procedures: Policy #UMXX_052 Enrollee Appeals- Expedited	03/25/2005 revised